REIMBURSEMENT FOR OUTPATIENT HOSPITAL SERVICES

A. COST BASED RETROSPECTIVE REIMBURSEMENT

Except for those services reimbursed as provided for in subsection B, all outpatient hospital services for all facilities identified in subsection C, will be reimbursed on a retrospective basis. The reimbursement period will be the provider's fiscal year.

Cost of hospital services will be determined for inpatient and outpatient care separately. Allowable costs will be determined in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants. Such definition of allowable costs is further defined in accordance with the Medicare Provider Reimbursement Manual, HCFA Pub. 15-1, subject to the exceptions and limitations provided in the Department's Administrative Rules. Pub. 15, is a manual published by the United States Department of Health and Human Services, Health Care Financing Administration, which provides guidelines and policies to implement Medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended.

All facilities identified in subsection C will be reimbursed on an interim basis during the facility's fiscal year. The interim rate will be a percentage of usual and customary charges. The percentage shall be the provider's cost-to-charge ratio determined by the facility's Medicare intermediary or by the Department under Medicare reimbursement principles, based upon the provider's most recent Medicare cost report. If a provider fails or refuses to submit the financial information, including the Medicare cost report, necessary to determine the cost to charge ratio, the provider's interim rate will be 60% of its usual and customary charges.

All In-State and Border hospitals will be required to submit a Medicare cost report in which costs have been allocated to the Medicaid program as they relate to charges. The facility shall maintain appropriate accounting records which will enable the facility to fully complete the cost report. Upon receipt of the cost report, the Department will instruct the Medicare intermediary to perform a desk review or audit of the cost report and determine whether overpayment or underpayment has resulted.

Out-of-state hospitals which are located more than 100 miles outside the border of the state of Montana and have more than $100,000 in interim payments for hospital services provided to Montana Medicaid recipients in the cost reporting period, will be required to submit a Medicare cost report in which costs have been allocated to the Medicaid program as they relate to charges. Upon receipt of the cost report, the Department will instruct the Medicare intermediary to perform a desk review or audit of the cost report and determine whether overpayment or underpayment has resulted. The Department may waive retrospective cost settlement for facilities which have received interim

payments totaling less than $100,000 for hospital services provided to Montana Medicaid recipients in the cost reporting period, unless the provider requests in writing retrospective cost settlement. Where the Department waives retrospective cost settlement, the provider's interim payments for the cost report period shall be the provider's final payment for the period.

Facilities will be required to file the cost report with the Montana Medicare intermediary within 150 days of the facility's fiscal year end or receipt of the department cost settlement detail reports, whichever is later.

Except as identified below, Medicare principles of reasonable cost reimbursement will be applied to cost settlement of those outpatient hospital services which are identified as being subject to cost based retroactive reimbursement:

For each hospital which is not a sole community hospital, as defined in ARM 46.12.503, reimbursement for reasonable costs of outpatient hospital services, other than the capital-related costs of such services, shall be limited to allowable costs, as determined less 7.0% of such costs.

For each hospital which is a sole community hospital, as defined in ARM 46.12.503, reimbursement for reasonable costs of outpatient hospital services, other than the capital-related costs of such services, shall be limited to allowable costs, as determined less 1.2% of such costs.

B. PROSPECTIVE REIMBURSEMENT

Except as otherwise specified, the following outpatient hospital services for all facilities as identified in subsection C, will be reimbursed under a prospective payment methodology for each service described as follows:

1. CLINICAL DIAGNOSTIC LABORATORY SERVICES

Clinical diagnostic laboratory services will be reimbursed on a fee basis as the lower of the provider's usual and customary charge or the applicable percentage of the Medicare fee schedule as follows: 60% of the prevailing Medicare fee schedule where a hospital laboratory acts as an independent laboratory, i.e., performs tests for persons who are non-hospital patients; 62% of the prevailing Medicare fee schedule for a hospital designated as a sole community hospital as defined in ARM 46.12.503; 60% of the prevailing Medicare fee schedule for a hospital that is not designated as a sole community hospital as defined in ARM 46.12.503. For clinical diagnostic laboratory services where no Medicare fee has been assigned, the fee is 62% of usual and customary charges for a hospital designated as a sole community hospital as defined in ARM 46.12.503 or 60% of usual and customary charges for a hospital that is not designated as a sole community hospital as defined in

ARM 46.12.503. Clinical diagnostic laboratory services include the laboratory tests listed in codes 80002-89399 of the Current Procedural Terminology, Fourth Edition (CPT-4). Certain tests are exempt from the fee schedule. These tests are listed in the HCFA Pub-45, State Medicaid Manual, Payment For Services, Section 6300. These exempt clinical diagnostic laboratory services will be reimbursed under the retrospective payment methodology.

2. EMERGENCY ROOM & CLINIC SERVICES

Emergency room and clinic services provided by hospitals that are not isolated hospitals or medical assistance facilities as defined in ARM 46.12.504(17) and (18) will be reimbursed on a fee basis for each visit. Emergency room and clinic services will be classified into one of three service groups for reimbursement purposes. Each service group will have two fees, one for sole community hospitals as defined in ARM 46.12.503, and one for non-sole community hospitals. Payment will be on a partially bundled basis (that is, hospitals will continue to be reimbursed separately for lab and imaging services but all other services on that day are bundled into the payment rates). The three service groups are defined as follows:

- Critical Care/Transfers: Critical emergency room visits are emergency room visits in which the recipient receives critical care procedures, dies while in the emergency room or is discharged or transferred to another short term general hospital for inpatient care. Critical care procedures are those procedures designated by the department as such and identified in the department's emergency room critical care procedures list.

- Emergency Room Visits: Emergency visits are emergency room visits for which the ICD-9-CM diagnosis code chiefly responsible for the services provided is a diagnosis designated as an emergency diagnosis in the Medicaid PASSPORT program Emergency Diagnosis List. The Passport Emergency Diagnosis List is periodically updated by the Montana Medicaid Provider Education Review Committee.

- Other ER/Clinic Visits: Other emergency room and clinic visits are emergency room and clinic visits that do not meet the criteria for the critical or emergency visit groups as specified above. Most of these visits are ER visits for non-urgent conditions and clinic visits that have been authorized by the PASSPORT provider.

The fees for emergency room and clinic service groups as described above for sole community hospitals and non-sole community hospitals are specified in the department's outpatient hospital emergency room & clinic fee schedule.

The fees for emergency room and clinic service groups are an all inclusive bundled payment per visit

which covers all outpatient services provided to the patient, including but not limited to nursing, pharmacy, supplies, equipment and other outpatient hospital services. Physician services are separately billable according to the applicable rules governing billing for physician services. In addition to the fee specified for each emergency room and clinic service group, Medicaid will reimburse providers separately for laboratory, imaging and other diagnostic services provided during emergency and clinic visits.

For hospital emergency room and clinic visits determined by the department to be unstable, the fee will be a stop-loss payment. If the provider's net usual and customary emergency room or clinic charges are more than 400% or less than 75% of the fee specified, the visit is unstable and the net charges will be paid at the statewide outpatient cost to charge ratio. For purposes of the stop-loss provision, the provider's net emergency room or clinic charges are defined as total usual and customary claim charges less charges for laboratory, imaging, other diagnostic and any non-covered services.

Emergency visits as defined above with ICD-9-CM surgical or major diagnostic procedure codes will be grouped into one of the ambulatory surgery day procedure groups.

3. NON-EMERGENT EMERGENCY ROOM SERVICES

Non-emergent emergency room services provided to a PASSPORT recipient, when the PASSPORT provider has not authorized the services, will be reimbursed a prospective fee of $20.30 per emergency room visit plus ancillary reimbursement for laboratory, imaging and other diagnostic services. The fee is a bundled payment per visit for all outpatient services provided to the patient including, but not limited to, nursing, pharmacy, supplies and equipment and other outpatient hospital services.

4. DIALYSIS SERVICES

Dialysis visits will be reimbursed at the provider's Medicare composite rate for dialysis services determined by Medicare under 42 CFR 413 subpart H. The facility's composite rate is a comprehensive prospective payment for all modes of facility and home dialysis and constitutes payment for the complete dialysis treatment, except for a physician's professional services, separately billable laboratory services and separately billable drugs. The provider must furnish all of the necessary dialysis services, equipment and supplies. Reimbursement for dialysis services and supplies is further defined in the Medicare Provider Reimbursement Manual, HCFA Pub. 15 (referred to as "Pub. 15"). For purposes of specifying the services covered by the composite rate and the services that are separately billable, the department hereby adopts and incorporates herein by reference Pub. 15.

5. IMAGING AND OTHER DIAGNOSTIC SERVICES

Imaging services will be reimbursed on a prospective basis by paying the lower of usual and customary charges or a fee basis. For each imaging service or procedure, the fee will be 160% of the technical component of the medicare resource-based relative value scale (RBRVS). For those services where there is no technical component under RBRVS, the fee will be 100% of the global value. For imaging services where no medicare fee has been assigned, the fee is 62% of usual and customary charges for a hospital designated as a sole community hospital or 60% of usual and customary charges for a hospital designated as a non-sole community hospital. The imaging services reimbursed under this plan are those individual imaging services listed in the 70000 series of the Current Procedural Terminology, Fourth Edition (CPT-4).

Other Diagnostic Services will be reimbursed on a prospective basis by paying the lower of usual and customary charges or a fee basis. For each diagnostic service or procedure, the fee will be 160% of the technical component of the medicare resource-based relative value scale (RBRVS). For those services where there is no technical component under RBRVS, the fee will be 100% of the global value. The individual diagnostic services reimbursed under this plan are those listed in the Current Procedural Terminology, Fourth Edition (CPT-4) in Addendum K to Chapter VII, Bill Review, of the Medicare Part A Intermediary Manual, Part 3 (HCFA Pub. 13-3).

6. AMBULATORY SURGERY SERVICES

Ambulatory surgery services provided by hospitals that are not isolated hospitals or medical assistance facilities as defined in ARM 46.12.504(17) and (18) will be reimbursed on a fee basis. A separate fee will be paid within each day procedure group depending on whether or not the hospital is a sole community hospital as defined in ARM 46.12.503. Payment for ambulatory surgery services is a fee for each visit determined as follows:

- The department assigns a day procedure group to each Medicaid visit as specified in the day procedure group (DPG) ambulatory surgery classification system developed by the Canadian Institute for Health Information (CIHI). The day procedure group system is an ambulatory surgery classification system that assigns patients to one of 66 groups according to the principal ICD-9-CM procedure code recorded on the UB-92 claim form.

- The department determines a fee for each day procedure group which reflects the estimated cost of hospital resources used to treat cases in that group relative to the statewide average cost of all Medicaid cases. Fees for day procedure groups for sole community hospitals and non-sole community hospitals are specified in the department's outpatient hospital fee schedule.

The payment for Ambulatory Surgery services is an all inclusive bundled payment per visit which

covers all outpatient services provided to the patient, including but not limited to nursing, pharmacy, Laboratory imaging services, other diagnostic services, supplies and equipment and other outpatient hospital services. For purposes of outpatient hospital ambulatory surgery services, a visit includes all outpatient hospital services related or incident to the ambulatory surgery visit that are provided the day before or the day of the ambulatory surgery event. Physician services are separately billable according to the applicable rules governing billing for physician services. Payment for certified registered nurse anesthetists (CRNAs) will be based on cost as a pass through in the cost settlement, as provided in ARM 46.12.505.

For hospital ambulatory surgery services, day procedure groups determined by the department to be unstable will be reimbursed a stop-loss payment. If the provider's net usual and customary charges are more than 400% or less than 75% of the fee specified, the day procedure group is unstable and the net charges will be paid at the statewide cost to charge ratio. For purposes of the stop-loss provision, the provider's net ambulatory surgery charges are defined as total usual and customary claim charges less charges for any non-covered services.

If the department's outpatient hospital ambulatory surgery fee schedule does not assign a fee for a particular DPG, the DPG will be reimbursed at the statewide average outpatient cost to charge ratio.

Ambulatory surgery services for which the primary ICD-9-CM procedure code is not included in the day procedure grouper, the service will be reimbursed under the retrospective cost basis.

7. STATEWIDE OUTPATIENT COST-TO-CHARGE RATIO
The Medicaid outpatient hospital statewide average cost to charge ratio equals 67 percent.

C. FACILITIES SUBJECT TO OUTPATIENT HOSPITAL REIMBURSEMENT
In-State Hospitals which include: large referral hospitals, other DRG hospitals, isolated hospitals, and medical assistance facilities. Such hospitals may be additionally classified as disproportionate share hospitals, rural hospitals, sole community hospitals, and hospitals providing outpatient psychiatric services.

Border Hospitals are those hospitals which are located within 100 miles of the border of the state of Montana.

Out-of-state Hospitals are those hospitals which are located beyond 100 miles of the border of the state of Montana.

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REIMBURSEMENT FOR RURAL HEALTH CLINICS

All rural health clinic services will be reimbursed on a retrospective basis. The reimbursement period will be the provider's fiscal year. Rural health clinics will be required to file a cost report to the department or its agent within 150 days after the close of the provider's reporting period.

A. PROVIDER-BASED RHCS IN RURAL HOSPITALS WITH LESS THAN 50 BEDS
Reimbursement will be the lower of the provider's usual and customary charges for RHC services or 100 percent of the reasonable costs of providing RHC services to Montana Medicaid recipients.

Reasonable cost shall be determined based upon the provider's Medicare hospital cost report for the reporting period, subject to desk review or audit, and according to Medicare cost reimbursement principles applicable to provider-based RHCs, as specified in 42 USC 1395x(v), as implemented by 42 CFR 405.2462(a) and 2468, 42 CFR Part 413, and the Medicare Provider Reimbursement Manual, HCFA Pub. 15.

B. PROVIDER-BASED RHCS IN RURAL HOSPITAL WITH 50 OR MORE BEDS AND INDEPENDENT RURAL HEALTH CLINICS
The payment limit for rural health clinic services is established in Section 1833 (f) of the Social Security Act. This is an all-inclusive rate which is based on the clinic's reasonable cost incurred in furnishing services under Medicare's regulations. The RHC's cost per visit for core services shall not exceed the applicable Medicare RHC per-visit payment cap for the RHC's reporting period.

Reimbursement will be a temporary all-inclusive rate per visit for core services and temporary all-inclusive rate(s) per visit for each category of other ambulatory services for each provider reporting period. The cost per visit for core services is subject to the applicable Medicare RHC per-visit payment cap pursuant to 42 CFR 405.2468(c), as set forth in section 505 of HCFA Pub. 27 and Medicare RHC productivity screening guidelines pursuant to 42 CFR 405.2468(c), as set forth in section 503 of HCFA Pub.27.

Other ambulatory services are not subject to the Medicare RHC productivity guidelines or the

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Medicare RHC per-vist payment cap. Other ambulatory services may have a separate rate for each category of other ambulatory services. Montana Medicaid will cover and reimburse RHC other ambulatory services only if the services are provided in accordance with the same requirements that would apply if the service were provided by an individual or entity other than an RHC

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Allowable RHC costs for core services shall be determined in accordance with Medicare reasonable cost principles as set forth in 42 CFR Part 413 and Medicare RHC allowable cost principles set forth in 42 CFR 405.2468, and HCFA manual provisions applicable to RHCs, including the Medicare provider reimbursement manual, HCFA Pub.15 and HCFA Pub. 27.

Allowable RHC costs for each category of other ambulatory services shall be determined in accordance with Medicare reasonable cost principles as set forth in 42 CFR Part 413 and Medicare RHC allowable cost principles set forth in 42 CFR 405.2468, and HCFA manual provisions applicable to RHCs, including the Medicare provider reimbursement manual, HCFA Pub. 15 and HCFA Pub. 27.

C. SUPPLEMENTAL PAYMENTS FOR MENTAL HEALTH SERVICES AND/OR HEALTH MAINTENANCE ORGANIZATION SERVICES

In accordance with Section 4712(b) (1) (B) of the Balanced Budget Act of 1997, the department will make payments to RHCs at least quarterly, of a supplemental payment equal to the amount, if any, by which the rates payable to the RHC by the Montana Medicaid program exceeds the amounts paid to the RHC by managed care organizations and/or health maintenance organizations for services provided to Medicaid recipients. The department will request documentation from the providers of the type of services provided, the mental health or HMO payment amount per service made to provider, the number of visits provided, the provider's Medicaid reimbursement rate or amount for each type of service, total amount of the supplemental payment due to the provider, along with the recipient name, social security number and date of service. This notice will be sent to providers 20-30 days prior to the end of each quarter. The department will make payments due to providers, if any, within 30 days of receipt of the above information from the provider. If no information is provided to the department from the provider, this will be interpreted that no request for payment is being pursued.

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D. RECONCILIATION AND SETTLEMENT OF INTERIM RATE PAYMENTS

All RHC providers are reimbursed on an interim basis until actual cost and visit or charge data is available. Final reimbursement rates are then determined based upon the actual data, and the difference between the interim and final rates is reconciled and settled. Because final reimbursement rates or amounts may not be available at the time supplemental payments are made, these payments also must be reconciled and settled upon determination of final rate or reimbursement amounts. This assures that providers are reimbursed based upon actual cost, charge and/or visit data, so that the department can assure compliance with the federal requirement that providers are reimbursed 100 percent of reasonable cost.

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REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS

All federally qualified health center services will be reimbursed on a retrospective basis. The reimbursement period will be the provider's fiscal year. Federally qualified health centers will be required to file a cost report to the department or its agent within 150 days after the close of the provider's reporting period.

A. INDEPENDENT FEDERALLY QUALIFIED HEALTH CENTERS

The payment limit for federally qualified health center services is established in Section 1833 (f) of the Social Security Act. This is an all-inclusive rate which is based on the center's reasonable cost incurred in furnishing services under Medicare's regulations. The FQHC's cost per visit for core services shall not exceed the applicable Medicare FQHC per-visit payment cap for the FQHC's reporting period.

Reimbursement will be a temporary all-inclusive rate per visit for core services and temporary all-inclusive rate(s) per visit for each category of other ambulatory services for each provider reporting period. The cost per visit for core services is subject to the applicable Medicare FQHC per-visit payment cap pursuant to 42 CFR 405.2468(c), as set forth in section 505 of HCFA Pub. 27 and Medicare FQHC productivity screening guidelines pursuant to 42 CFR 405.2468(c), as set forth in section 503 of HCFA Pub.27.

Other ambulatory services are not subject to the Medicare FQHC productivity guidelines or the Medicare FQHC per-vist payment cap. Other ambulatory services may have a separate rate for each category of other ambulatory services. Montana Medicaid will cover and reimburse FQHC other ambulatory services only if the services are provided in accordance with the same requirements that would apply if the service were provided by an individual or entity other than an FQHC.

Allowable FQHC costs for core services shall be determined in accordance with Medicare reasonable cost principles as set forth in 42 CFR Part 413 and Medicare FQHC allowable cost principles set forth in 42 CFR 405.2468, and HCFA manual provisions applicable to FQHCs, including the Medicare provider reimbursement manual, HCFA Pub.15 and HCFA Pub. 27.